FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0017590

Facility Name: BARRY COMMUNITY CARE CENTER

Address: 1313 PRATT STREET (Number) BARRY (City) 62312 (Zip Code)

County: PIKE

Telephone Number: (217) 335-5326 **Fax #** (217) 335-7031

HFS ID Number: 370990780001

Date of Initial License for Current Owners: 1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: YVONNE CHUA **Telephone Number:** (636) 394-3000

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JAMES J GIARDINA

(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) DARRYL E. BUEKER, CPA

(Firm Name & Address) BKD, LLP; PO BOX 1190; SPRINGFIELD, MO 65801-1190

(Telephone) (417) 865-8701 Fax # (417) 865-0682

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,890	7,812	1,927	21,629	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,890	7,812	1,927	21,629	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.97%

D. How many bed-hold days during this year were paid by the Department?
5 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/ 22 /75

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 76 and days of care provided 1,806

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	146,991	12,310	4,716	164,017		164,017		164,017			1
2	Food Purchase		96,412		96,412		96,412	(9,861)	86,551			2
3	Housekeeping	90,027	13,679		103,706		103,706	150	103,856			3
4	Laundry	16,307	11,683		27,990		27,990		27,990			4
5	Heat and Other Utilities			66,787	66,787		66,787		66,787			5
6	Maintenance	22,639	39,408	24,672	86,719		86,719	104	86,823			6
7	Other (specify):*											7
8	**TOTAL General Services**	275,964	173,492	96,175	545,631		545,631	(9,607)	536,024			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	857,997	102,230	3,627	963,854		963,854		963,854			10
10a	Therapy		725	169,917	170,642		170,642		170,642			10a
11	Activities	38,876	5,800	1,771	46,447		46,447		46,447			11
12	Social Services	22,357		1,771	24,128		24,128		24,128			12
13	CNA Training			1,521	1,521		1,521		1,521			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	919,230	108,755	179,807	1,207,792		1,207,792		1,207,792			16
	C. General Administration											
17	Administrative	49,976			49,976		49,976	7,780	57,756			17
18	Directors Fees											18
19	Professional Services			171,960	171,960		171,960	(163,622)	8,338			19
20	Dues, Fees, Subscriptions & Promotions			11,905	11,905		11,905	(5,008)	6,897			20
21	Clerical & General Office Expenses	23,472	6,113	22,367	51,952		51,952	41,673	93,625			21
22	Employee Benefits & Payroll Taxes			198,474	198,474		198,474	7,769	206,243			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,892	8,892		8,892	4,239	13,131			24
25	Other Admin. Staff Transportation							48	48			25
26	Insurance-Prop.Liab.Malpractice			53,747	53,747		53,747	42	53,789			26
27	Other (specify):*											27
28	**TOTAL General Administration**	73,448	6,113	467,345	546,906		546,906	(107,079)	439,827			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,268,642	288,360	743,327	2,300,329		2,300,329	(116,686)	2,183,643			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER #0017590 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,402	51,402		51,402		51,402			30
31	Amortization of Pre-Op. & Org.			4,379	4,379		4,379	(4,132)	247			31
32	Interest			106,285	106,285		106,285	(33,936)	72,349			32
33	Real Estate Taxes			46,638	46,638		46,638		46,638			33
34	Rent-Facility & Grounds							8,050	8,050			34
35	Rent-Equipment & Vehicles			793	793		793	1,851	2,644			35
36	Other (specify):*											36
37	**TOTAL Ownership**			209,497	209,497		209,497	(28,167)	181,330			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):* **LAB**			2,704	2,704		2,704		2,704			43
44	**TOTAL Special Cost Centers**			44,314	44,314		44,314		44,314			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,268,642	288,360	997,138	2,554,140		2,554,140	(144,853)	2,409,287			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,689)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(492)	32		10
11	Discounts, Allowances, Rebates & Refunds	(14)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(172)	2		13
14	Non-Care Related Interest	(33,444)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(202)	21		18
19	Entertainment	(474)	24		19
20	Contributions	(1,533)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,001)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(123)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,144)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(4,132)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(89,577)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (93,709)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (144,853)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs	X		57,348	10.2	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 57,348		47

STATE OF ILLINOIS

BARRY COMMUNITY CARE CENTER

ID# 0017590

Report Period Beginning: 1/1/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,861)	0	0	0	0	0	0	0	0	0	0	(9,861)	2
3	Housekeeping	0	150	0	0	0	0	0	0	0	0	0	150	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	104	0	0	0	0	0	0	0	0	0	104	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,861)	254	0	0	0	0	0	0	0	0	0	(9,607)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	7,780	0	0	0	0	0	0	0	0	0	7,780	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(163,622)	0	0	0	0	0	0	0	0	0	(163,622)	19
20	Fees, Subscriptions & Promotions	(5,124)	116	0	0	0	0	0	0	0	0	0	(5,008)	20
21	Clerical & General Office Expenses	(1,749)	43,422	0	0	0	0	0	0	0	0	0	41,673	21
22	Employee Benefits & Payroll Taxes	0	7,769	0	0	0	0	0	0	0	0	0	7,769	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(474)	4,713	0	0	0	0	0	0	0	0	0	4,239	24
25	Other Admin. Staff Transportation	0	48	0	0	0	0	0	0	0	0	0	48	25
26	Insurance-Prop.Liab.Malpractice	0	42	0	0	0	0	0	0	0	0	0	42	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(7,347)	(99,732)	0	0	0	0	0	0	0	0	0	(107,079)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(17,208)	(99,478)	0	0	0	0	0	0	0	0	0	(116,686)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(4,132)	0	0	0	0	0	0	0	0	0	0	(4,132)	31
32	Interest	(33,936)	0	0	0	0	0	0	0	0	0	0	(33,936)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,050	0	0	0	0	0	0	0	0	0	8,050	34
35	Rent-Equipment & Vehicles	0	1,851	0	0	0	0	0	0	0	0	0	1,851	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(38,068)	9,901	0	0	0	0	0	0	0	0	0	(28,167)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(55,276)	(89,577)	0	0	0	0	0	0	0	0	0	(144,853)	45

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J GIARDINA	100	MAR-KA NURSING HOME	MASCOUTAH	COMMUNITY	BALLWIN, MO	HOME OFFICE
		WEST MAIN NURSING HOME	MASCOUTAH	CARE CENTERS, INC		
		MONMOUTH NURSING HOME	MASCOUTAH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	HOME OFFICE	$ 165,600	COMMUNITY CARE CENTERS, INC.	COMMON	$	$ (165,600)	1
2	V	34	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	8,050	8,050	2
3	V	35	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	1,851	1,851	3
4	V	17	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	7,780	7,780	4
5	V	21	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	43,422	43,422	5
6	V	22	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	7,769	7,769	6
7	V	19	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	1,978	1,978	7
8	V	24	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	4,713	4,713	8
9	V	25	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	48	48	9
10	V	6	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	104	104	10
11	V	20	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	116	116	11
12	V	26	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	42	42	12
13	V	3	HOME OFFICE		COMMUNITY CARE CENTERS, INC.	COMMON	150	150	13
14	Total			$ 165,600			$ 76,023	$ * (89,577)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	WORKERS COMP INS	$ 45,449	RISA	25.00%	$ 45,449	$	15
16	V	26	LIABILITY INS	45,689	IMPEDIA	100.00%	45,689		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 91,138			$ 91,138	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES J GIARDINA	PRESIDENT	GEN DIRECTOR	100.00	NONE	3	6.00	SALARY	$ 4,873	19.3	1
2	BETTY HUGHES	SECRETARY		0.00	NONE	2	4.35	SALARY	2,907	19.3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,780		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	HOME OFFICE	DIRECT COST			$	$		$	1
2		WEST COUNTY CARE CENTER						5,226,170	204,040	2
3		ST GENEVIEVE CARE CENTER						2,276,178	83,017	3
4		CCC OF LEMAY						2,209,896	77,382	4
5		SALEM CARE CENTER						1,784,077	66,551	5
6		MONMOUTH NURSING HOME						2,119,149	72,051	6
7		MAR-KA NURSING HOME						2,826,853	116,866	7
8		WEST MAIN NURSING HOME						344,196	11,798	8
9		CCC OF SENECA						2,458,662	90,264	9
10		MT. VERNON PLACE CARE						2,510,965	85,740	10
11		COUNTRY VIEW NSG FAC						1,936,002	77,926	11
12		MERAMEC NURSING CENTER						2,678,946	118,210	12
13		SEVILLE CARE CENTER						2,596,921	90,895	13
14		SALEM RES CARE						5,407,419	18,084	14
15		BOSS RES CARE						130,669	4,372	15
16		CARL JUNCTION RES CARE						626,569	20,967	16
17		MT VERNON RES CARE						429,610	14,375	17
18		SENECA HOME PLACE						444,391	14,870	18
19		HUDSON HOUSE						482,781	16,155	19
20		MAPLE GROVE LODGE						2,559,000	113,915	20
21		CCC OF AURORA						4,079,498	137,650	21
22		BARRY COMMUNITY CARE						2,169,252	76,023	22
23		LICKING RES CARE						259,092	8,671	23
24		COMMUNITY IN HOME SER						673,248	29,379	24
25	TOTALS					$	$		$ 1,549,201	25

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FIRST NAT'L BANK OF BARRY		X	MORTGAGE	$8,049.29	1/13/00	$ 962,000	$		8.0000	$ 40,634	1
2	FIRST NAT'L BANK OF BARRY		X	MORTGAGE-REFINANCE	$11,632.51	9/6/05	1,500,000	1,490,936	9/6/08	7.0000	25,834	2
3	FARMERS & MERCHANTS BANK		X	2003 CHEVY SAVANA	$569.25	4/18/04	19,175	8,803	5/2/07	4.2500	520	3
4												4
5												5
	Working Capital											
6	FIRST NAT'L BANK OF BARRY		X	WORKING CAP-LOC				50,000		VAR	5,853	6
7												7
8												8
9	TOTAL Facility Related				$20,251.05		$ 2,481,175	$ 1,549,739			$ 72,841	9
	B. Non-Facility Related*											
10	UNION PLANTERS BANK		X	STOCK BUYOUT	$3,438.87	5/24/00	400,000			8.2500	22,584	10
11	JOHN HUBBARD	X		STOCK BUYOUT	$3,870.35	5/24/00	319,000			8.0000	10,860	11
12												12
13												13
14	TOTAL Non-Facility Related				$7,309.22		$ 719,000	$			$ 33,444	14
15	TOTALS (line 9+line14)						$ 3,200,175	$ 1,549,739			$ 106,285	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	34,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	46,638	2
3. Under or (over) accrual (line 2 minus line 1).	$	11,838	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	34,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	46,638	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	36,599	8
	2001	39,475	9
	2002	40,940	10
	2003	43,142	11
	2004	46,638	12

ACCRUAL - SAME AS PRIOR YEAR

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BARRY COMMUNITY CARE CENTER COUNTY PIKE

FACILITY IDPH LICENSE NUMBER 0017590

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE (636) 394-3000 FAX #: (636) 394-7713

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	46-031-09	RNG/BLK:6 TWP:04 SECT/LOT:25	$ 46,638.32	$ 46,638.32
2.		PT S SIDE NE	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,638.32	$ 46,638.32

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,930 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	5.04 ACRES	1973	$ 20,739	1
2					2
3	TOTALS	5.04 ACRES		$ 20,739	3

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		Feb-75	1975	$ 805,055	$ 9,073	30	$ 9,073	$	$ 805,055	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PATIO			1976	936		20			936	9
10	DRIVE			1987	3,002	95	31	95		1,753	10
11	ROOF			1995	27,030	1,802	15	1,802		19,372	11
12	BLACKTOP DRIVE			1998	6,300	420	15	420		3,078	12
13	NEW CARPET - LIVING ROOM DISPOSAL 2005			2001		398	5	398			13
14	NEW CARPET DISPOSAL 2005			2001		424	5	424			14
15	NEW CEILING			2001	12,227	1,223	10	1,223		5,197	15
16	CARRIER ROOF TOP UNIT			2001	10,980	1,098	10	1,098		5,032	16
17	AIR HANDLER A/C FOR KITCHEN			2001	1,137	114	10	114		511	17
18	LIGHT FIXTURES, PAINT			2001	1,441	144	10	144		600	18
19	76 RESIDENT ROOM WALL BRACKET LIGHTS			2001	6,656	666	10	666		2,774	19
20	FIRE ALARM SYSTEM			2004	2,121	212	10	212		407	20
21	AMER STANDARD 15T RFTOP A/C			2004	11,475	1,147	10	1,147		1,912	21
22	FIRE SUPPRESSION SYSTEM			2005	2,005	200	10	200		200	22
23	85-GALLON WATER HEATER			2005	5,016	251	10	251		251	23
24	CARPET-FOYER, OFFICES			2005	5,373	269	5	269		269	24
25	TILE FLOORING DIN RM, LV RM			2005	5,598	140	10	140		140	25
26	PAINTING			2005	15,490						26
27	WAINSCOTING			2005	4,187						27
28	CEILING LIGHT FIXTURES			2005	1,121						28
29	WALLPAPER			2005	8,958						29
30	OUTDOOR LIGHTS			2005	1,188						30
31	LANDSCAPING			2005	7,080	118	10	118		118	31
32	BRICK SIGN			2005	4,895	41	10	41		41	32
33	CONCRETE WORK			2005	1,931	11	15	11		11	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 951,202	$ 17,846		$ 17,846	$	$ 847,657	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 184,988	$ 27,110	$ 27,110	$		$ 136,876	71
72	Current Year Purchases	71,061	1,653	1,653			1,653	72
73	Fully Depreciated Assets	126,671					126,013	73
74								74
75	TOTALS	$ 382,720	$ 28,763	$ 28,763	$		$ 264,542	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	2003 CHEVY SAVANA	2003	4/18/2004	$ 19,175	$ 4,793	$ 4,793	$	4	$ 8,389	76
77										77
78										78
79										79
80	TOTALS			$ 19,175	$ 4,793	$ 4,793	$		$ 8,389	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,373,836	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,402	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 51,402	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,120,588	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 793 Description: LP TANK $50; STORAGE UNIT $180; BACKHOE $520; FLOOR BUFFER $43
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [X] YES
   - [ ] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM: [ ]
   - IN OTHER FACILITY: [ ]
   - COMMUNITY COLLEGE: [X]
   - HOURS PER CNA: 80

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM: [ ]
   - IN OTHER FACILITY: [X]
   - HOURS PER CNA: 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,231	$	$ 1,231
2	Books and Supplies		136		136
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		154		154
9	TOTALS	$	$ 1,521	$	$ 1,521
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,521			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$	316	$ 72,545	$ 541	316	$ 73,086	1
2	Licensed Speech and Language Development Therapist	10a	hrs		110	20,328		110	20,328	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		343	77,043	184	343	77,227	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	769	$ 169,916	$ 725	769	$ 170,641	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BARRY COMMUNITY CARE CENTER **#** 0017590 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 103,862	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	407,575		3
4	Supply Inventory (priced at COST)	2,050		4
5	Short-Term Investments			5
6	Prepaid Insurance	28,336		6
7	Other Prepaid Expenses	22,855		7
8	Accounts Receivable (owners or related parties)	1,052,136		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,616,814	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,739		13
14	Buildings, at Historical Cost	951,201		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	401,894		16
17	Accumulated Depreciation (book methods)	(1,115,588)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	53,884		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(49,834)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	1,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 263,296	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,880,110	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 511,107	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	50,000		29
30	Accrued Salaries Payable	80,257		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,184		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTIES	144,376		36
37	PT FUNDS/UNEARNED INCOME	98,935		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 928,659	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,803		39
40	Mortgage Payable	1,490,936		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,499,739	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,428,398	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (548,288)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,880,110	$	48

***(See instructions.)**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (446,802)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (446,802)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(26,486)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(75,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (101,486)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (548,288)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,735,300	1
2	Discounts and Allowances for all Levels	(7,744,814)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,990,486	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	406,104	6
7	Oxygen	120,265	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 526,369	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,688	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,688	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	717	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 717	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	A/P DISCOUNTS	14	28
28a	TRAVEL CHG TO RESDIENT	380	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 394	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,527,654	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	545,631	31
32	Health Care	1,207,792	32
33	General Administration	546,906	33
	B. Capital Expense		
34	Ownership	209,497	34
	C. Ancillary Expense		
35	Special Cost Centers	2,704	35
36	Provider Participation Fee	41,610	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,554,140	40
41	**Income before Income Taxes (line 30 minus line 40)****	(26,486)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (26,486)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,953	2,168	$ 49,055	$ 22.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,307	6,685	126,806	18.97	3
4	Licensed Practical Nurses	12,984	13,719	183,716	13.39	4
5	CNAs & Orderlies	53,042	55,546	494,101	8.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,882	2,069	20,627	9.97	9
10	Activity Assistants	2,198	2,416	18,249	7.55	10
11	Social Service Workers	1,891	2,100	22,357	10.65	11
12	Dietician					12
13	Food Service Supervisor	3,225	3,525	32,620	9.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,715	10,555	82,998	7.86	15
16	Dishwashers	4,717	4,825	31,373	6.50	16
17	Maintenance Workers	2,033	2,115	22,639	10.70	17
18	Housekeepers	11,047	11,695	90,027	7.70	18
19	Laundry	1,831	2,023	16,307	8.06	19
20	Administrator	2,011	2,093	49,976	23.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,989	2,172	23,472	10.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	442	446	4,320	9.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	117,267	124,152	$ 1,268,643 *	$ 10.22	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	127	$ 4,716	1.3	35
36	Medical Director	96	1,200	9.3	36
37	Medical Records Consultant	36	1,500	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,127	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	1,771	11.3	44
45	Social Service Consultant	27	1,771	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	409	$ 13,085		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DOUG MILLS	ADMINISTRATOR		$ 32,486
PATRICIA HUBBARD	ADMINISTRATOR		17,490
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 49,976

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
COMMUNITY CARE CENTERS, INC.	MGT FEES	$ 165,600
VARIOUS	LEGAL FEES	360
BKD, LLP	ACCOUNTING	6,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 171,960

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,449
Unemployment Compensation Insurance	
FICA Taxes	121,748
Employee Health Insurance	24,587
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	5,470
OSHA EMPLOYEE BENEFITS	31
401K CONTRIBUTION	1,189
HOME OFFICE ALLOCATION	7,769
TOTAL (agree to Schedule V, line 22, col.8)	$ 206,243

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	964
Health Care Worker Background Check	592
(Indicate # of checks performed 74)	
DUES & SUBSCRIPTIONS	3,266
TAXES & LICENSES	1,859
ADVERTISING - OTHER	5,224
HOME OFFICE ALLOCATION	116
Less: Public Relations Expense	( )
Non-allowable advertising	(5,001)
Yellow page advertising	(123)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,897

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,335
MEALS	474
Seminar Expense	2,083
HOME OFFICE ALLOCATION	4,713
Entertainment Expense	(474)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,131

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 **Report Period Beginning:** 1/1/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC $4,195**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **3-10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **41,610**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation. CONFERENCE IN LAKE OZARK, MO
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **50%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **N/A**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.